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SOUTHAMPTON CITY COUNCIL

# Southampton Health and Care Partnership Board

Thursday, 19th October, 2023
at 9.30 am

**PLEASE NOTE TIME OF MEETING**

## Council Chamber - Civic Centre

**THIS MEETING IS OPEN TO THE PUBLIC**

**Please send apologies to Natalie Johnson**
**email: natalie.johnson@southampton.gov.uk**

**AGENDA**

**1 WELCOME AND APOLOGIES**

| Lead | **Item For:**<br>**Discussion**<br>**Decision**<br>**Information** | **Attachment** |
|---|---|---|
| Chair | Information | None |

**2 DECLARATIONS OF INTEREST**

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

| Lead | **Item For:**<br>**Discussion**<br>**Decision**<br>**Information** | **Attachment** |
|---|---|---|
| Chair | Information | None |

**3 MINUTES OF THE PREVIOUS MEETING/ ACTION TRACKER** (Pages 1 - 4)

| Lead | **Item For:**<br>**Discussion**<br>**Decision**<br>**Information** | **Attachment** |
|---|---|---|
| Chair | Information | Attached |

**4 5 YEAR HEALTH & CARE STRATEGY - ANNUAL UPDATE AND COMMITMENTS** (Pages 5 - 32)

To receive a presentation detailing the 5 Year Health & Care Strategy Annual Update and Commitments. Presentation attached.

| Lead | **Item For:**<br>**Discussion**<br>**Decision**<br>**Information** | **Attachment** |
|---|---|---|
| Sarah Turner | Discussion | Presentation Attached |

**5 BETTER CARE FUND (BCF) DELIVERY & PERFORMANCE REPORT** (Pages 33 - 56)

Report of the Deputy Leader and Cabinet Member for Adults, Health and Housing detailing BCF delivery and performance.

| Lead | **Item For:**<br>**Discussion**<br>**Decision**<br>**Information** | **Attachment** |
|---|---|---|
| Terry Clark | Discussion | Report Attached |

11th October 2023 Director of Legal, Governance and HR

# Meeting Minutes

## Southampton Health & Care Partnership Board– Public

**The meeting was held on Thursday 16TH February 2023, 09:30 - 11:30**
**Council Chamber, Civic Centre Southampton**

| | | INITIAL | TITLE | ORG |
|---|---|---|---|---|
| **Present:** | | | | |
| | Councillor Lorna Fielker | Cllr Fielker | Cabinet Member – Health and Adults and Leisure | SCC |
| | James House | JH | Managing Director (Southampton) | ICB |
| | Dr Sarah Young | SY | Clinical Director | ICB |
| | Terry Clark | TC | Director of Commissioning Health and Care | ICB/SCC |
| | Claire Edgar | CE | Executive Director of Wellbeing & Housing (DASS) | SCC |
| **In attendance:** | | | | |
| | Moraig Forrest-Charde | MFC | Deputy Director Integrated Commissioning Unit | ICB/SCC |
| | Claire Heather | CH | Senior Democratic Support Officer | SCC |
| | Matthew Richardson | MR | Deputy Director Integrated Commissioning Unit | ICB/SCC |
| | Keith Petty | KP | Senior Finance Business Partner | SCC |
| | Angela Murrell (minutes) | AM | PA (Southampton Place) | ICB |
| **Apologies:** | | | | |
| | Rob Henderson | RH | Executive Director Wellbeing (Children & Learning) | SCC |
| | Debbie Chase | DChas | Director of Public Health | Public Health |
| | Donna Chapman | DC | Deputy Director Integrated Commissioning Unit | ICB/SCC |
| | Kay Rothwell | KR | Deputy Director of Finance Southampton & Portsmouth | ICB |
| | Councillor Satvir Kaur | Cllr Kaur | Leader | SCC |
| | Councillor Daniel Paffey | Cllr Paffey | | SCC |
| | Vernon Nosal | VN | Director of Operations, Adult Social Care | SCC |

| | Action: |
|---|---|

| | | |
|---|---|---|
| **1.** | **Welcome and Apologies** | |
| | Members were welcomed to the meeting.<br><br>Apologies were noted and accepted. | |
| **2.** | **Declarations of Interest** | |
| | **A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship**<br><br>No declarations were made above those already on the Conflict-of-Interest register. | |
| **3.** | **Minutes of the previous (Public) meeting** | |
| | The Board reviewed the minutes from the previous meeting dated 15th December 2022 were agreed as an accurate reflection of the meeting.<br><br>**Matters Arising**<br>There were no matters arising. | |
| **4.** | **Health & Care Quality Report** | |
| | MR attended the meeting to present the Health & Care Quality Report highlighting the following key points: -<br>• Some pressures on CQC ratings particularly within our bedded care within our residential and some nursing capacity.<br>• Working closely with the CQC to deliver the improvements.<br>• Health system continues to have significant challenges due to high winter demand.<br>• All GP practices are currently CQC rated as good.<br><br>Cllr Fielker commented that the report was a very informative, noting the main theme running through the report of the high-level risk due to workforce demands in every area of the system.<br><br>CE asked if we have received an update from Southern Health in terms of their action plan.<br><br>MR stated that there are regular meetings in place with Southern Health to go through their action plans.<br><br>TC confirmed that the South-Central Ambulance and Southern Health reports have gone to the Health and Overview Scrutiny Panel and updates continue to go as the Committee request them.<br><br>Cllr Fielker asked if the decrease in CQC ratings has a particular | |

| | | |
|---|---|---|
| | theme/issue.<br><br>MR stated that the themes and issues are all very similar and consistent both regionally and nationally. A credible plan is in place support the Care homes.<br><br>Cllr Fielker asked are we getting feedback from the providers on how we are supporting them and if they require any additional support from us.<br><br>MR stated we have recently asked the market to do a training needs analysis and what support they value from us; they would value more clinical input from health particularly around mental health and challenging behaviour.<br><br>**Action: MR to explore with the market on what further support they may need.**<br><br>The Board noted the Health and Care Quality report. | **MR** |
| **5.** | **Better Care Fund Performance Update QTR 3** | |
| | MFC attended the meeting to present the Better Care Fund Performance update quarter 3, highlighting the key following points: -<br>• MFC will amend the report to show correct date from 2022/23 to 2023/24<br>• Financial performance is as expected, MFC highlighted 2 of the variations from plan, which is partly due to the additional funding received, Adult Social Care Discharge Fund and additional Community Discharge Grant these were both significant changes. MFC stated that the Joint Equipment Services continues to have pressures, mainly due to the complexity of the service users, MFC working closely with this service to help keep the pressures down.<br>• Metrics - Avoidable Admissions is in an acceptable position, and Discharge to usual place of residence is also looking positive at this current point.<br>• Risks – MFC stated that there are no new risks. Hospital Discharge fund continues to be a risk.<br><br>CE stated that the data looks strong, but the operational teams may report different, and that it is important we are keeping a close eye on this activity, and how are we maximising the IBCF and BCF to ensure we are being cost effective and sustainable going forward.<br><br>**Action: CE/TC/MFC to discuss/show how we are future planning for the IBCF and BCF**<br><br>CE asked if we could consider how we wish to present the data on the effectiveness of the pathway to adulthood.<br>MFC suggested to bring a presentation on the pathway to adulthood towards year end, with specific detail particularly Learning Disablilities | **CE/TC/MFC** |

| | | |
|---|---|---|
| | TC confirmed that this will be part of the 2023/24 Better Care Fund planning once the guidance has come out and will ensure that this is added to the forward plan.<br>Cllr Fielker noted that the metrics for the residentials admissions there is a significant difference between quarter two and quarter three can this be explained.<br>MFC stated that currently we do not have the detail of why there is a significant difference and have asked that we are provided with some narrative to help explain this to put into the year end report.<br><br>Cllr Fielker asked what mitigation is in place for meeting the key requirements for the carers strategy.<br>MFC stated that the two strategies are progressing alongside each other and progressing well and will bring both plans back to a future meeting.<br>JH proposed that with regards to the metrics it would be helpful to have a transformational conversation.<br><br>The Board noted the Southampton's Health & Care Partnership Board. | |
| **5.** | **Date of Next Meeting** | |
| | 16th March 2023 – 09:30-11:30 - Briefing | |

# Southampton City Five Year Health and Care Strategy 2020-2025

# Update for 2023/24

# Southampton City Health and Care Strategy

## 2020-2025

### Our vision

**A healthy Southampton where *everyone* thrives**

### Our goals

Reducing **inequalities** and confronting **deprivation**

Working with people to build **resilient communities** and **live independently**

Improving **earlier help, care and support**

Tackling the city's **biggest killers**

Improving **mental and emotional** wellbeing

Improving **joined-up, whole-person care**

### Our priorities

**Start Well**

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

**Live Well**

People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

**Age Well**

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

**Die Well**

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

Five key enabling priorities:

- Digital
- Workforce
- Estates
- Primary Care
- Urgent & Emergency Care

# Approach to 2023/24 Work Programme

The following slides provide an update on the Five-Year Health and Care Strategy 2023-2025, on the high priority areas for each of the 4 Workstreams: Start Well, Live Well, Age Well, Die Well for the Health and Care Partnership Board.

The key areas of focus are defined as those which:

- Require a **whole system approach** – all partners will have a contribution to make
- Will make a **significant impact** on the health and wellbeing of people in Southampton
- Address **key issues** that the city has been struggling to grapple with

As in previous years, the 2023/24 work programme will not attempt to repeat all the other plans that are in existence (e.g. Health & Wellbeing Strategy, Children & Young People's Plan, Mental Health Transformation Plans, Age Well Strategy and single agency plans). Instead, it will acknowledge and add value to these by bringing a collective focus to a few key areas where a more joined up approach across the system is needed to address a key issue



# Reminder of our five year vision for Start Well

## Start Well

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

In five years time, we want children and young people in Southampton to:

- Live happy, healthy lives, with good levels of physical and mental wellbeing
- Be safe at home and in the community, with Southampton being a child-friendly, family focussed city.
- Have good levels of educational attainment, fulfil their potential and go on to successful opportunities in adulthood.
- Live in communities which are resilient, engaged and prepared for the future.

# Key points – Children and Young people

- **Smoking at time of delivery** (11%) **higher** but not **significantly** than England (10%). Previous years significantly higher. Recent years show **Southampton** percentage **decreasing faster** rate **than nationally.**
- **Breastfeeding** prevalence at 6-8 weeks after birth **increasing** and **higher** than **national** average (53% vs. 45%)
- **Excess weight** in 4/5 years old significantly higher and 10/11 years old higher than England and with a steeper overall increase, (see slide 27) 2020/21 uses local data as published data for all local authorities unavailable due to insufficient pandemic-related coverage
- **Children Looked After rate** similar 2019 to 2021, **higher than England** but **gap reducing. School readiness** following national **increases** and **MMR vaccination** (age 2) recent years **significantly higher** and **increasing** overall trend vs. **national decline**
- Teenage conception **decreased overall** at a **faster** rate than **nationally** over **last 15 years**, despite significantly higher than England in 2020 (2018 and 2019 was statistically similar)
- **Children** in relative **low income** families, **consistently significantly higher** than England and **gap getting worse**
- Hospital admissions caused by **unintentional and deliberate injuries** in **children** under 15 years **lowest rate** in last 10 years



| Priority area | Measure | Unit | Time period | Southampton Sparkline | Southampton value | England value | ONS (n=12) Comparator Ranking (1 is worse, worst third in pink) | Significance compared to England value |
|---|---|---|---|---|---|---|---|---|
| Children & Young People/Early years | Smoking status at time of delivery (Female) | % | 2020/21 | | 10.7 | 9.6 | 5 | Higher |
| | Breastfeeding prevalence at 6-8 weeks after birth - current method | % | 2020/21 | | 53.4 | 47.6 | 2 of 5 | Significantly higher |
| | Child excess weight in 4-5 year olds | % | 2020/21 | | 32.7 | 27.7 | Insufficient data | Significantly higher |
| | Child excess weight in 10-11 year olds | % | 2020/21 | | 41.0 | 40.9 | Insufficient data | Higher |
| | Population vaccination coverage - MMR for one dose (2 years old) | % | 2020/21 | | 93.7 | 90.3 | 8 | Higher |
| | Children looked after | per 10,000 | 2021 | | 96.0 | 67.0 | 3 | Significantly higher |
| | School readiness: Good level of development at the end of reception | % | 2018/19 | | 71.1 | 71.8 | 9 | Lower |
| | School readiness: Year 1 pupils achieving the expected level in the phonics screening check | % | 2018/19 | | 82.1 | 81.8 | 10 | Higher |
| | Children in relative low income families (under 16s) | % | 2020/21 | | 22.2 | 18.5 | 6 | Significantly higher |
| | Hospital admissions caused by unintentional &deliberate injuries in children (aged 0-14 yrs) | per 10,000 | 2020/21 | | 65.0 | 75.7 | 9 | Significantly Lower |
| | Under 18s conception rate / 1,000 (Female) | per 1,000 | 2020 | | 20.7 | 13.0 | 2 | Significantly higher |

# Inequalities – Children and Young

**Comparing outcomes for children and young people in the most deprived 20% of Southampton to the least deprived 20%, illustrates the inequality gap in the city.**

**Mothers smoking at booking**

**4.1x higher**

**Breastfeeding at initial check**

**1.4x lower**

**Child poverty**

**3.7x higher**

**Healthy weight**

**1.1x lower** for Year R children

**1.2x lower** for Year 6 children

**Average Attainment 8 Score**

**1.3x Lower**



**Youth Violent Crime**
(per 1k children)

**3.2x higher**

**Drug use**
(per 1k children)

**7.8x higher**

**Alcohol use**
(per 1k children)

**5.1x higher**

**Children experiencing neglect or abuse**
(per 1k children)

**4.9x higher**

**Looked after children**

**4.1x higher**

**Mental Health/ Psychosocial condition**
(per 1k children)

**1.5x higher**

Note: Uses local deprivation quintiles

# Start Well – Original Roadmap

| Year | What we said we were going to do in the strategy |
|---|---|
| **Year 1 2022/21** | • **Year of the Child**<br>• **Early Help** locality model<br>• Local **foster care** offer expanded<br>• Two **mental health** support teams in schools established<br>• **Phoenix** specialist family service goes live<br>• Implementation of **children's psychiatric liaison service** |
| **Year 2 2021/22** | • **Children's Hospital at Home** service goes live<br>• Expansion of **mental health support teams** in schools and a whole school approach to mental health and wellbeing<br>• **Employment and training** opportunities expanded for young people<br>• Development of **local residential** provision |
| **Year 3 2022/23** | • **0-25 year service** offer in place<br>• Expansion of **mental health support** teams in schools<br>• **Employment and training** opportunities further expanded for young people |
| **Year 4 2023/24** | • **Family Hubs** offer rolled out across the city in line with the Government Best Start for Life vision with focus on tackling inequalities<br>• Improved support for young people with **SEND/additional needs** preparing for adulthood<br>• Improved short break offer for children with SEND and parenting support in place for families of **children with Neurodiversity** of all ages<br>• **MH Support Team** offer rolled out to all mainstream primary, secondary and colleges and home educated pupils<br>• Development of Southampton Children and Young People's **Mental Health Crisis Resolution and Home Treatment Team**<br>• Improved mental health support to **children in care and vulnerable young people**, and the professionals working with them<br>• Launch of **BeeWell survey** within secondary schools<br>• Southampton officially launches as a **Child Friendly City**<br>• **Development of Young Southampton** – an alliance of voluntary and community sector organisations supporting young people |

# Start Well – Progress to date

## What have we done in the last 12 months?

- Developed **Family Hub offer** (7 Family Hubs) including recruitment of Perinatal MH practitioners, implementation of breastfeeding rooms and peer champions in all Family Hubs and roll out of parenting support (26 parenting courses)
- UHS has adopted **UNICEF Baby Friendly Initiative** to support breastfeeding
- Implementation of **Kooth on-line** counselling service for 11-25year olds
- New counselling contract with **No Limits** - increased capacity for young people 0-18
- **Emotional health training** programme piloted in Southampton with the Anna Freud Centre – 500 staff and volunteers have signed up
- Implementation of a new **Preparing for Adulthood (PFA)** Assessment Team in the Council to provide more timely assessment and pilot of a PFA community navigation service to support young people access the support and activities available in their communities. Development of an Employment Guide. Transition Fair run by Re:minds in March 23.
- Sign up to the Local Authority **Declaration for Healthy Weight**
- **Autism in Schools programme** rolled out to 15 schools in Southampton
- Early Bird, Early Bird Plus, Cygnet and New Forest **Parenting Programmes** introduced across the city for parents of children with Neurodiversity
- **Early LifeLab** programme rolled out to all primary schools
- Expanded range of SEND friendly and **inclusive holiday programmes** in the city (HAF)
- Completion of **Discovery and Development phases of UNICEF Child Friendly City**



## What are we planning in the next 12 months

- Officially **launch Child Friendly City** in November 2023
- Roll out of **#Beewell Health and Care** survey to all secondary schools from Sept 23
- Completion of refurbishment and mobilisation of Westwood Short Stay residential unit to support children at risk of hospital admission or long term residential care
- Recommissioning of **short breaks for children with SEND**, broadening the offer of support, particularly for those at the medium level of need and with neurodiversity
- Roll out **Autism in Schools programme** to all schools and colleges in the city
- **Further develop Family Hubs,** embedding Perinatal MH practitioners, rolling out PEEP training to support parents help their child's development and learning pre-school
- **Remodel the 5-19 Public Health Nursing Service** – focus on national High Impact areas
- Roll out **MH Support Teams** to 10 remaining primary schools in Southampton
- Implement the new **CAMHS support offer to children** looked after and vulnerable young people and the professionals who work with them
- Continue to improve support for **young people preparing for adulthood** – implementation of new mental health access coordination service, Improved support to vulnerable young people and care leavers to access housing and employment
- Develop an **all-age neurodivergent strategy** along with piloting a new **Autism Hub**
- Embed expanded **community mental health crisis support** covering evenings and weekends
- Development of sustainable model of assessment and support for **children with neurodiversity,** including potential roll out of Neurodiversity profiling tool in the city

## Impact

- Reduced hospital admissions for children with mental health issues since introduction of acute psychiatric liaison offer – from 47% pre 2022 to 27% in 23/24
- Reduced short stay hospital admissions for common acute childhood illness by 17% since introduction of Hospital at Home Service
- During 2022/23 28% of mothers stopped smoking during pregnancy reducing the overall percentage to 9.6%, only slightly above the national average of 9.1%
- 81% of babies breastfed in Southampton at 7-10 days are still breastfeeding at 6-8 weeks which puts Southampton above the national average
- More to do:
  - Referrals into specialist CAMHS continue to rise and Waiting list for for Autism/ADHD assessments continue to rise
  - Outcomes for young people with additional needs preparing for adulthood have still to improve (e.g. those not in employment, education and training)
  - Impact on percentage of children with healthy weight – too early to tell



# Reminder of our five year vision for Live Well

## Live Well

People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

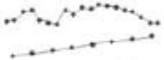
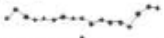
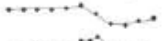
In five years time, we want people in Southampton to:

- Live healthier, for longer
- Be happy in life and feel supported by their family, friends and local community
- Live independently and feel confident to take care of their own health and wellbeing
- Live in a city which is fully accessible.

# Key points – Adults

- **Smoking prevalence** in adults **decreasing** overall, 2019 data (16.8%) significantly higher than England (13.9%), 2020 has cautionary flag around data collection, true value is expected to lie between 2019 and 2020 values
- **Suicide rate** (2019-21 9.5 per 100k) **similar to England** and lowest rate in last 12 three-year pooled periods, however **coroner** hearings and **registered** dates may have been **delayed** due to **COVID-19**.
- Local **depression prevalence** (12.4%) has **increased** similarly **along** with **national** rates (12.3%) for 2020/21
- Under 75 mortality from **preventable liver disease**, data 2016-18 & 2017-19 **highest since 2001-03**, **significantly higher** than **England**
- **HIV late diagnosis** in people first diagnosed with HIV in the UK, now 37% continues with a 4th consecutive 3 year pooled period **lower** than **national average** (43%)
- **TB incidence locally** (9.8 per 100k) **significantly higher** than England (8.6 per 100k) and **lowest** since 2001-03
- **Injuries due to falls** in those aged 65+ **increasing overall** whilst **England average** remained **stable**, pandemic period saw falls locally and nationally decline in line with stay-at-home/social distancing compliance



| Priority area | Measure | Unit | Time period | Southampton Sparkline | Southampton value | England value | ONS (n=12) Comparator Ranking (1 is worse, worst third in pink) | Significance compared to England value |
|---|---|---|---|---|---|---|---|---|
| Adults | Smoking Prevalence in adults (18+) - current smokers (APS) | % | 2020 |  | 11.8 | 12.1 | 8 | Lower |
| | | | 2019 | | 16.8 | 13.9 | 3 | Significantly higher |
| | Suicide rate (age 10+ years) | per 100,000 | 2019 - 21 |  | 9.5 | 10.4 | 11 | Lower |
| | Depression: Recorded prevalence (aged 18+) | % | 2020/21 |  | 12.4 | 12.3 | 4 | Higher |
| | Injuries due to falls in people aged 65+ (Persons) | per 100,000 | 2020/21 |  | 2918.6 | 2023.0 | 2 | Significantly higher |
| | Injuries due to falls in people aged 65+ years (Male) | per 100,000 | 2020/21 |  | 2659.4 | 1667.3 | 2 | Significantly higher |
| | Injuries due to falls in people aged 65+ years (Female) | per 100,000 | 2020/21 |  | 3092.8 | 2284.8 | 3 | Significantly higher |
| | Under 75 mortality rate from liver disease considered preventable (2019 defn) | per 100,000 | 2017 - 19 |  | 23.2 | 16.7 | 3 | Significantly higher |
| | HIV late diagnosis in people first diagnosed with HIV in the UK | % | 2019 - 21 |  | 37.3 | 43.4 | 10 | Lower |
| | TB incidence (3 year average) | per 100,000 | 2018 - 20 |  | 9.8 | 8.0 | 3 | Higher |

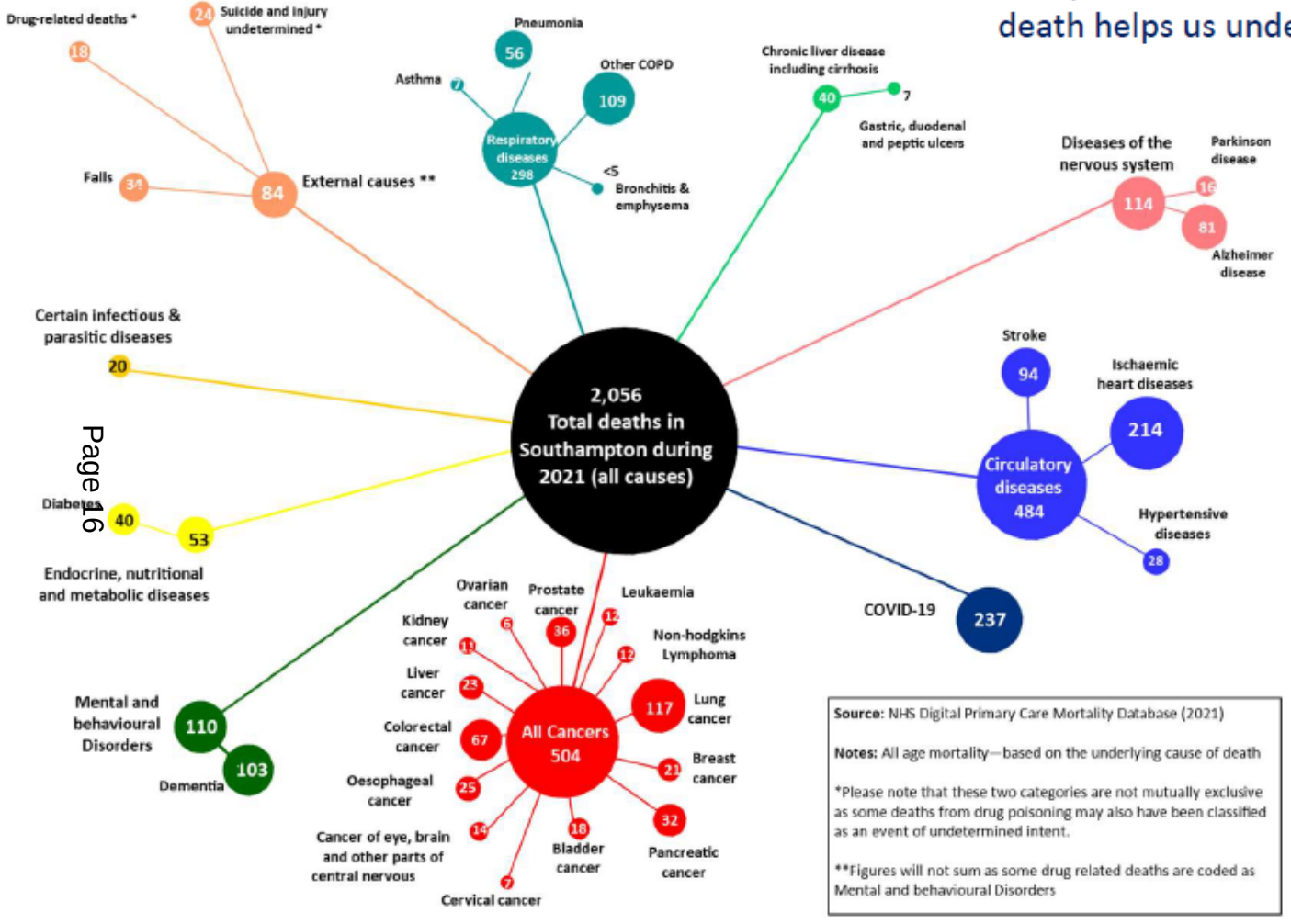
# Key points – Healthy settings

- 2020 saw fraction of **mortality attributable to particulate air pollution higher** than **England average** (6.3 versus 5.6%)
- **Excess winter deaths not significantly different** to **England average** and follows national warm/cold winter trends. The data has not be revised at local authority level for Winter 2020 to 2021 which nationally showed a growth of excess winter deaths driven by the large number of coronavirus (COVID-19) deaths in the non-winter months of 2020 (April to July) and the winter months of 2021 (December to March).
- Data for **people in employment** to end of March 2021 saw Southampton significantly higher than England, however the impact of COVID-19 has since seen significant increases and also sub-city variation (see slides on benefits in Covid Impact Assessment section)



| Priority area | Measure | | Time period | Southampton Sparkline | Southampton value | England value | ONS (n=12) Comparator Ranking (1 is worse, worst third in pink) | Significance compared to England value |
|---|---|---|---|---|---|---|---|---|
| Healthy settings | Fraction of mortality attributable to particulate air pollution (new method) | % | 2020 | | 6.3 | 5.6 | 2 | Not comparable |
| | Percentage of people aged 16-64 in employment | % | 2020/21 | | 80.0 | 75.1 | 11 | Significantly Higher |
| | Excess winter deaths index (Persons) | Ratio | Aug 2019 - Jul 2021 | | 7.4 | 17.4 | 11 | Lower |
| | Excess winter deaths index (Male) | Ratio | Aug 2019 - Jul 2021 | | 11.0 | 17.5 | 11 | Lower |
| | Excess winter deaths index (Female) | Ratio | Aug 2019 - Jul 2021 | | 3.6 | 17.3 | 11 | Lower |

## Some causes of deaths are more common than others.




**Source:** NHS Digital Primary Care Mortality Database (2021)

**Notes:** All age mortality—based on the underlying cause of death

*Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.

**Figures will not sum as some drug related deaths are coded as Mental and behavioural Disorders

## Analysis of the **trends, patterns** and **comparisons** for cause of death helps us understand **priorities** for **health** and **wellbeing**

**Comparing** proportions of **deaths by cause** with proportions of **years of life lost by cause** shows which groups impact younger people disproportionately:

**External causes** account for **4.1% of deaths** in **2021** but **14.5% of years of life lost.**

**Suicide and injury undetermined** are the **largest** part of this accounting for **3.1% of deaths** and **7.4% of year of life lost**

**Drug related deaths** account for **0.9% of deaths** in 2021 and **5.3% of year of life lost**

**Liver disease (incl. cirrhosis)** is the underlying cause for **1.9% of deaths** and **6.3% of years lost**

# Inequalities - Mortality

## In the most deprived quintile compared to the least…

### All Causes

All age mortality

**1.4x higher**

Premature (u75) mortality

**2.0x higher**

### Cancer

All age mortality

**1.4x higher**

Premature (u75) mortality

**1.5x higher**

### Circulatory Disease

All age mortality

**1.3x higher**

Premature (u75) mortality

**1.9x higher**

### COPD

All age mortality

**2.9x higher**

Note: Uses local deprivation quintiles

# Live Well – Original Roadmap

| Year | What we said we were going to do in the strategy |
|---|---|
| **Year 1 2022/21** | • **Lung health checks** fully implemented to increase the early detection and survivorship of lung cancer<br>• Patients will be able to receive a **definitive cancer diagnosis** within 28 days of referral<br>• Community **Cardiology and Respiratory** service developed<br>• Psychological therapy support available for people with cardiovascular or gastrointestinal conditions<br>• Development of **integrated Diabetes service** that will be measured on improving outcomes for patients living with diabetes<br>• Introduce risk stratification to identify individuals with a **learning disability** who have the greatest need<br>• Expand portfolio of **housing options** for those with a learning disability/mental health need<br>• Implement **"The Lighthouse"** community-based facility to support those experiencing a mental health crisis<br>• Review best practice models for mental health services accessed by **rough sleepers** |
| **Year 2 2021/22** | • New Southampton **alcohol** strategy launched<br>• All patients have access to **on-line and video consultations** for their GP surgery<br>• Every person diagnosed with cancer will have access **to personalised care** including a care plan and health and wellbeing information and support<br>• **Follow-up support** for people who are worried their cancer may have recurred will be in place<br>• New **heart failure** and breathlessness services developed<br>• People with a **mental health** condition will be able to access digitally-enabled therapy and **Therapeutic care** from inpatient MH services will be improved<br>• Implement an effective mental health pathway for **rough sleepers** to access integrated holistic care, long term care and support |
| **Year 3 2022/23** | • Community **Cardiology and Respiratory** service fully in place<br>• Implement new mental health services for **rough sleepers**<br>• Every person diagnosed with cancer will have access **to personalised care**, including a care plan and health and wellbeing information and support<br>• **Follow-up support** for people who are worried their cancer may have recurred will be in place |
| **Year 4 2023/24** | • Implementation of **16-25 mental health pathway** to support young people preparing for adulthood, including co-produced Mental Health online resource.<br>• **Community Mental Health Transformation:** broadening the offer within PCNs to include support for social determinants of mental health (carer support, housing, employment alongside the social prescriber role).<br>• Increased uptake of **Serious Mental Illness physical health check** and access to physical activity/behavioural change offer<br>• Development of **supported housing strategy** for people with Mental Health issues.<br>• Expand access to NHS Talking Therapies (previously known as Improving Access to Psychological Therapies - IAPT)<br>• Proactive care for **people with long term conditions**, with focus on Heart Failure, Cardiac Rehabilitation and Breathlessness (incl. diagnosis of COPD and asthma<br>• Increase **Diabetes** education (NDPP) uptake targeting at risk groups and review transition pathway from children to adult services<br>• Reduce **Tobacco Dependence** through targeted work with PCNs, maternity, homeless settings, mental health and acute inpatient settings.<br>• Continuation of services to reduce number of **rough sleepers** through additional government funding.<br>• Improve the quality and quantity of **Learning Disability Annual Health Checks** and Plans (including improved access to cancer screening)<br>• Pilot a **Neurodiversity** Hub providing advice and support |

# Live Well – Progress to date

## What have we done in the last 12 months?

- Reduced **Tobacco Dependence** through commissioned Smokefree Southampton Solutions service, PCNs, maternity and homeless settings.
- Continuation of services to reduce number of **rough sleepers**
- Reviewed **sexual health** services, re-procurement of service.
- Recommissioned **Domestic Violence**
- Commissioned a **Housing First** service
- More **supported living** properties for adults with learning disabilities and MH needs.
- Launched **new Integrated Diabetes** service in 2022
- Achievement of **'exemplary' quality mark for Southampton Mental Health Individual Placement and Support Service**
- Development of **16-25 Mental Health pathways**.
- Development of new **PCN based Enhanced Primary Care Mental Health roles**, delivering evidence based individual and group intervention in Primary Care settings.
- Embedded integrated working between Primary Care, IAPT, secondary care services
- Introduction of **Serious Mental Illness physical health check** facilitator to support Primary Care and provision of point of care testing technology in every GP Practice.
- Completed **Mental Health Housing Needs Assessment** & Market Position Statement
- Launched Southampton **MH grant giving scheme**, Saints by you Side programme for men, Mayfield Nurseries horticultural therapy programme.
- Development of Southampton **Mental Health Network** and Southampton Mental Illness Lived Experience (SMILE) Network
- Additional **Mental Health support for Rough Sleepers**
- Introduction of **Early Intervention in Psychosis cannabis prevention** peer-led group
- **Gambling Harm Clinic** launch in Southampton
- Development of a **second Lighthouse in Bitterne**
- New **Suicide and Bereavement Support Service (Amparo)** and ICS Wide Mental Health Digital development of SHOUT, linked back to the 111 Mental Health Triage.
- Developed easy-read guidance for **cancer screening**
- Improved use of **learning disabilities housing** stock in the city

## Impact

- 60% of people experiencing 1st episode **psychosis** treated within 2 weeks of referral
- 7 more adults with **LD** supported to move from residential care into supported living
- Referral target achieved for **Diabetes** education programme – 6703 people referred
- Employment - 210 people accessed **MH Individual Placement** and Support Service
- People with **LD in paid employment** increased from a low of 2.9% during Covid, to 4.4%
- Improved use of **housing stock -** void rates reduced from 17% in 21/22 to current rate of 3%
- **Smoking** prevalence in adults decreasing overall
- **Suicide** rate reducing
- More to do:
  - **Cancer, CVD and Respiratory disease** - prevalence much higher in most deprived areas
  - Uptake of **LD health checks** remains below target, poorer health & wellbeing outcomes
  - Local **depression** prevalence increased

## What are we planning in the next 12 months?

- Target **tobacco dependency** support in deprived areas and those facing inequalities (mental health, homeless) by training more front-line staff in behaviour change interventions.
- Mobilise new **Integrated Reproductive Sexual Health Service** (IRSHS) across HIOW
- Development of an **Early Intervention and Prevention strategy**
- Continue to improve **proactive and preventative care for people with long term conditions,** focusing on Heart Failure, Cardiac Rehab, Breathlessness
- Continue to increase **Diabetes education** (NDPP) uptake through community engagement officer, offering non-English language programmes, and pilot of hospital referrals
- Implementation of **16-25 mental health pathway**.
- Co-produce offer for people with **co-occurring MH issues and substance use** disorder
- Continue to increase uptake **of Serious Mental Illness physical health check**
- Development of **supported housing strategy for people with MH issues**
- Increase access to NHS **Talking Therapies**
- **Inclusive Lives procurement**: inclusive, strengths-based care & support for people with LD
- Improve uptake of Learning Disability Annual Health Check
- Deliver 29 new **Supported Living tenancies** for adults with learning disabilities
- Maximise use of Faecal Immunochemical Testing to detect **bowel cancer**

# Mental Health Case Studies

## Mental Health Case Studies

Improved patient experience and outcomes - case studies



## Case Studies

**SMI physical health outreach and Point Of Care technology**

- 63 year old agoraphobic gentleman on SMI register
- Referred for SMI physical health check by surgery due to attempts to contact
- Invite letter sent and contacted by patient who consented to visit by SMI health facilitator
- Visited patient at home and SMI health check completed
- Blood test identified onset of diabetes
- CWT HCA supporting gentleman with new diagnosis, self-management including use of glucometer
- Reassurance and advice around medications/treatments provided
- Ongoing support with referrals to other services, including accessing dentist and optician

**Integrated working between Enhanced Primary Care Mental Health team and PCN social prescribers**

- Patient referred by social prescriber
- Presented with Low mood, anxiety, ruminating thoughts, suicidal ideation and self harm
- Assessed within 5 days and offered brief intervention 6 sessions. Included psychoeducation and developing coping skills and strategies. Used online self-help resources and guided interventions workbooks
- Positive feedback from patient as anxiety lessened and able to resume activities; avoided medication

**Early detection and support to avoid step up to secondary care**

- Patient had diagnosis of Bi-Polar who was experiencing a manic phase of her illness, referred by GP to EPCMHT
- Triaged on the day and prevented full relapse, early detection and avoided secondary services
- Medication advice and guidance and support from nurse ensured deterioration managed and did not escalate
- Positive feedback from patient and family due to timely response, support to family and less disruption to family life

**Peer Recovery Workers**

- Recovery peer worker supported patient in peer recovery group
- Presentation; highly anxious, social phobia and reduced level of functioning
- Outcome; able to attend group and looking at voluntary work
- Positive feedback 'I would like to thank peer worker and NHS for wisdom and support for giving me light at end of tunnel and could not imagine this prior to treatment'



# Reminder of our five year vision for Age Well

## Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

In five years time, we want people in Southampton to:

- Be able to maintain their health, wellbeing and independence into old age, stay living in their own homes and feel part of their local communities.
- Be supported to recover from illness in their own home wherever possible and only go to or stay in hospital when needs can't be met in the community.
- Be supported by collaborative and integrated working between health, social care and housing support.
- Be able to access the right support, at the right time, in the right place, as close to home as possible.
- Feel in control of their health and wellbeing, be part of any decision about their care and have the information and support they need to understand and make choices.

# Performance against key measures

- Hospital admissions relat**ed to Injuries due to falls** in adults **aged 65+ significantly higher than England average** and our peers, although has reduced in recent years
- **Permanent admissions to residential care has been decreasing but still significantly higher than England** average and most of our comparators
- **Suicide rates amongst males aged 65+ higher than England average** and worse amongst our comparators, though have been reducing
- **Deaths from respiratory disease significantly higher than England average** and our comparators
- **Life expectancy lower for both men and women than England average**
- Adults living in income **deprived households** significantly **higher than England average**

| Priority Area | Measure | ID | Units | Latest data | Southampton Value | England Value | Significance compared to Engand |
|---|---|---|---|---|---|---|---|
| Older People | Dementia: QOF prevalence (all ages) | 247 | % | 2020/21 | 0.5 | 0.7 | Lower |
| | Emergency hospital admissions due to falls in people aged 65 + (female) | 22401 | per 100,000 | 2021/22 | 3,418.0 | 2,360.0 | Significantly Higher |
| | Emergency hospital admissions due to falls in people aged 65 + (male) | 22401 | per 100,000 | 2021/22 | 2,915.2 | 1,749.6 | Significantly Higher |
| | Emergency hospital admissions due to falls in people aged 65 + (persons) | 22401 | per 100,000 | 2021/22 | 3,186.8 | 2,099.9 | Significantly Higher |
| | Life expectancy at 65 (female) | 91102 | Years | 2021 | 40.9 | 41.9 | Lower |
| | Life expectancy at 65 (male) | 91102 | Years | 2021 | 34.6 | 36.9 | Lower |
| | Mortality rate from all cardiovascular diseases, ages 65+ yrs | 92718 | per 100,000 65+ | 2021 | 1,179.3 | 1,021.4 | Significantly Higher |
| | Mortality rate from respiratory disease, ages 65+ yrs | 92725 | per 100,000 65+ | 2021 | 568.0 | 440.8 | Significantly Higher |
| | Older people in poverty: Income deprivation affecting older people index (IDAOPI) | 93279 | % | 2019 | 17.3 | 14.2 | Significantly Higher |
| | Percentage of people aged 65+ using social care who receive self-direct payments | 92729 | % | 2021/22 | 94.3 | 93.2 | Higher |
| | Permanent admissons to residential and nursing care home per 100,000 aged 65+ | 1194 | per 100,000 | 2021/22 | 644.5 | 538.5 | Significantly Higher |
| | Suicide crude rate 65+ years: per 100,000 (5 year average) (male) | 91430 | per 100,000 | 2013-17 | 19.2 | 12.4 | Higher |
| | Winter mortality index (age 85+) | 90361 | Ratio | Aug 2019 - Jul 2021 | 7.4 | 17.4 | Lower |

# Age Well – Original Roadmap

| Year | What we said we were going to do in the strategy |
|---|---|
| **Year 1 2022/21** | • **Integrated community teams**, 'One Team', across Southampton – beginning to operate<br>• **Enhanced healthcare teams** supporting all residential and nursing homes across the city<br>• **Community navigators** (social prescribers) in place across Primary Care<br>• Exercise classes in place for **people at risk of falling**<br>• More **dementia friendly spaces** in place<br>• **Extra Care housing scheme** at Potters Court opens<br>• Risk stratification rolled out to **tackle inequalities** and case manage people with the greatest needs<br>• Multi-agency services at the hospital front door – with a '**Home First' principle** |
| **Year 2 2021/22** | • **Care technology** support becoming the norm in enabling people to maintain their independence<br>• Health and care professionals using **single care plans** enabled through technology<br>• Single **intermediate care team** operating across hospital, community & primary care |
| **Year 3 2022/23** | • **Integrated community transport** service in place<br>• More **intergenerational opportunities** and older people volunteering<br>• Further increase in **Extra Care homes** available<br>• Health and care professionals across all sectors, including care homes and home care providers making **active use of single care plans** to share information and use technology to seek rapid advice from each other<br>• **Enhanced healthcare teams** providing support to **extra care housing** |
| **Year 4 2023/24** | • Full range of **community support activities** on offer<br>• **Age Well friendly City**<br>• **People actively managing their health**, utilising technology, self-managed care plans with easy access to information, advice and guidance<br>• Integrated community teams working across localities utilising population management tools – delivering strengths based, joined up, proactive care and support<br>• **Mental Health support** fully embedded in the locality team offer<br>• More people **supported to stay at home/maintain their independence** for as long as possible – stronger focus on getting people back home after a hospital stay<br>• **Care Homes proactively managing the health needs** of their residents |

# Age Well –Progress to date

## What have we done in the last 12 months?

- A **reablement business case** and subsequent improvement groups have been developed
- The **Joint Equipment Store** has increased the amount of DFG activity and minor works it undertakes which reduces unnecessary assessment and promotes timeliness.
- Continued "One Team" pilot, informing development of Integrated Neighbourhood Teams
- The **Virtual Ward** model has further developed and is operating at an optimum level.
- Roll out of **Enhanced Health in Care Homes** support delivered by PCN's across the city.
- Southampton **Dementia Festival** showcasing information on support opportunities for those people living with dementia, their family and carers; Re-commissioning of Dementia Friendly Southampton bringing together community groups, charities, businesses and residents & Increase in provision of Memory Cafes
- **Increased occupancy of extra care schemes** (to 94%) and review of need bandings to enable gradual increase in the complexity of need that can be met within extra care.
- Support for **adult social care workforce** around recruitment, retention and training
- A new **Market Position Statement** for older person care services.
- Publication of **market sustainability plan** based on the cost of care exercise
- Re-procurement and increased **market diversity in home care**, with 29 new providers joining the Home Care Platform
- **Transfer of Care Hub** set up to support hospital discharge – promoting home first approach
- **Care technology** rolled out across Virtual Wards and Care Homes promoting independence.



## What are we planning in the next 12 months?

- Operationalise the reablement business case increasing **reablement to community referrals**
- Develop a more **integrated** whole system approach to **proactive joined up local care and support**, including greater use of care technology to help people maintain independence
- Reset **Carers Strategy** in line with contextual change in the city
- Further maximise opportunities to use the **DFG** to better support people's independence
- Continued review and development of **discharge to assess model**
- Revisit the **Falls Strategy** to ensure it is aligned strategically.
- Continued development of **community navigation**, taking referrals from the Adult Social Care front door
- Implement learning from Hampshire and Isle of Wight ICB **Dementia group** to develop a recovery plan to achieve Dementia Diagnosis targets
- Develop plans for **Older Persons Mental Health** community based support including crisis and in reach into Nursing Homes
- Confirm commissioning intentions regarding future use of **RSH** site for adult social care
- Implement new banding system for extra care as part of re-tender
- Continued workforce support to the market with a more specific focus on the **personal assistant market** (for those with direct payments).
- Implement and monitor new **hospital discharge community navigation** service
- Re-tendering existing extra care schemes through the Home Care Platform
- Concluding a review of the community transport offer in the City

## Impact

- Over 95% people now discharged "home first" from hospital supporting a more strengths based, independence promoting approach
- More to do:
  - Hospital admissions in relation to falls remain very high
  - Permanent admissions to residential homes for people aged 65+ remain high
  - High rates of avoidable unplanned hospital admissions
  - High rates of suicide amongst males 65+



# Reminder of our five year vision for Die Well

## Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

What do we want to be different in five years' time?:

- More people will be supported to stay at home when they experience a decline in their health within their last years of life.
- There will be no disparity in access to and provision of end of life care across the Southampton geography.
- More people will achieve their preferred place of care and death where this is practical to do so.
- Early identification and end of life discussions will be the norm; more people will be describing their end of life wishes and preferences.
- There will be local, compassionate communities who are confident to talk about and support friends and neighbours who may be experiencing death and dying.
- Proactive, personalised care planning to help people to consider their end of life wishes and options for a Personal Health Budget will be available?
- More palliative care and end of life patients will have continuity of care and support across all health and care settings.
- Bereavement care will improve the involvement, support and care for all those important to the dying person.

# Performance against key measures

- Data for this workstream is limited by what is readily available and so has focussed on place of death – consideration will need to be given to additional metrics in future, e.g. uptake of personal budgets, early identification of people on End of Life Register
- Percentage of deaths that occur in usual place of residence (all ages) has been increasing but is below the England average – this is similar for cancers, dementia and circulatory diseases but respiratory deaths in usual place of residence are slightly higher than the England average

| Priority Area | Measure | ID | Units | Latest data | Southampton | England | Significance compared to Engand |
|---|---|---|---|---|---|---|---|
| Die Well | Deaths in usual place of residence: People with dementia (aged 65+) ( Persons) | 91887 | % | 2019 | 67.8 | 70.3 | Similar |
| | Percentage of deaths that occur at home (persons) | 93476 | % | 2021 | 29.0 | 28.7 | Similar |
| | Percentage of deaths that occur in care homes (persons) | 93475 | % | 2021 | 18.4 | 20.2 | Similar |
| | Percentage of deaths that occur in hospital (persons) | 93474 | % | 2021 | 43.0 | 44.0 | Similar |

# Die Well – Original Roadmap

| Year | What we said we were going to do in the strategy |
|---|---|
| **Year 1 2022/21** | • **24/7 coordination centre** with access to rapid response 24 hours advice, support and home visits<br>• Development of **end of life champions**, linking with primary care and communities<br>• **Bereavement services** expanded<br>• Review the provision of **access to end of life services** for professionals and the families of children at or approaching end of life |
| **Year 2 2021/22** | • **Nurse led unit** in place at Countess Mountbatten Hospice<br>• **Independent hospice provision** in place for Southampton<br>• Everyone in a care home is identified on an **end-of-life register** with an advance care place in place<br>• **End-of-life training** available to home care staff<br>• Work with children's services and families to **design local end-of-life services for families and children** |
| **Year 3 2022/23** | • Development of an **end-of-life school's programme** |
| **Year 4 2023/24** | • Childrens end-of-life care services in place with bank of **end-of-life children's home care/sitting service**<br>• Continued development of **24/7 end of life Care Coordination Centre**<br>• **Improved hospital discharge processes** to support more people to **die in the place of their choice**<br>• Increased ea**rly identification of people at end of life** to support more proactive care planning<br>• **Improved bereavement support**<br>• **Addressing inequalities in access to end of life** care (e.g. people with learning disabilities, homeless people) |

# Die Well – Progress to date

## What have we done in the last 12 months?

- **Palliative Care Support Workers** are now part of the care coordination centre, which is run 24/7 by Mountbatten Hampshire
- A **discharge facilitator** is now in place working across UHS and the hospice inpatient unit. The main focus on this role is to facilitate quicker fast track discharges from hospital.
- Two **nurse led respite beds** are now in place and have been working well for the past 12 months.
- An intensive **communications programme** with stakeholders i.e. Primary Care, Acute, Social prescribers, 111, 999 (paramedics) to raise awareness of the breadth of end of life and palliative care (EOL&P) services available in Southampton and the importance of early referral to the EOL&P care service.
- Opened a **social space** for the general public based at Mountbatten Hampshire which includes a café/restaurant and supports those feeling socially isolated.
- Roll out of a time limited/funded programme to **deliver bereavement and wellbeing support to residential and nursing home staff in Southampton** following impact of Covid19. This has led to a direct reduction in sickness for the care homes who engaged.
- Increase in the numbers of **nurse prescribers** within Mountbatten Hampshire, which aims to reduce the impact on Primary Care, 111 etc to prescribe drugs.
- Development of an **end of life care coordination register** in conjunction with key stakeholders.
- Embedded **spiritual care** as mandatory training for all Mountbatten staff
- Mountbatten Hampshire employed an **LD nurse** to support patients and families with a diagnosis of a LD who are EOL and to be a point of reference for staff.
- The **Southampton Homeless and substance user's forum** has been reinstated and training needs for staff identified for this cohort, supported by a tailored education programme. Includes shadowing in hostels and at Mountbatten.



## Impact

- Percentage of **deaths that occur in usual place of residence** has been increasing – reduction in deaths in hospital
- More people being **identified earlier** for support in the community – Mountbatten's community case load has grown from <500 in April 2020 to 1,400 in June 2023
- More to do:
  - **Deaths in usual place of residence** lower than England average for dementia
  - **Bereavement support**

## What are we planning in the next 12 months?

- **Developing a broader spiritual care offer**, pre and post bereavement, which includes working with local clergy to identify a resource of all faiths.
- **Training of teachers** in bereavement support providing psychological skills.
- **Partnerships between adult and children's EOL services** to support Children and Young Adults in transition (in conjunction with ICB).
- End of life provider and care homes, to strengthen **collaborative working** and increase the number of end of life patients registered with Advance Care Plans (ACP)
- Explore how **personal health budgets** might be implemented for those fast track patients

# Health and Care Commitments supporting workstream priorities

## Start Well

- **Strengthening Early Help through integrated local support in communities (1st 1001 days)**
- **Improving Emotional & Mental health of children & families through earlier intervention & promotion of positive MH**
- Increase opportunities for all young people & particularly the most vulnerable, in education, housing, employment, training
- Improve outcomes for children with SEND
- **Promoting healthy weight – to include City wide roll out of Healthy High Five & Healthy Early years Award**

## Live Well

- **Reduce harm from tobacco, alcohol and drugs**
- **Improve the life chances of the most vulnerable, in particular people with MH problems, LD & other disadvantages & reduce inequalities, through improved opportunities for housing, employment & training**
- **Improving mental health & tackling loneliness**
- Improving cancer screening & early identification
- Improving outcomes for people with diabetes
- **Promoting healthy weight**

## Commitments

All partners are signed up to the following commitments in support of each of the workstream priorities to address the city's cross cutting issues & challenges:

1. A "**one team**" locality based approach which brings health & care teams together with local communities, informed by population health management, to proactively identify & support children, families & adults
2. A **Trauma informed** workforce
3. **Whole city campaigns** targeted at healthy weight, smoking, mental health & harm from drug and alcohol
4. An **Infrastructure** which promotes health & wellbeing:
    - Health in all Policies
    - Sign up to Healthy Weight declaration
    - Recruitment practice that targets opportunities towards vulnerable groups
    - Purchasing locally for social benefit
    - Smoke free settings
    - One public estate

## Age Well

- Improving support to enable people to maintain their health, wellbeing and independence into old age
- Support more people to receive the right services at the right time & in the right place, through proactive, integrated support, embedded in local communities
- **Improve mental health, emotional wellbeing & tackle loneliness**
- Improve identification of and support for carers

## Die Well

- **Early identification of people at End of Life to improve outcomes through proactive personalised care planning**
- Promote accessibility & equality of End of Life care for everyone, with a particular focus on groups who have poorer outcomes, e.g. homeless, people with LD, dementia
- Improve Out of Hospital End of Life Care Co-ordination

# Health and Care Commitments

| Workstream | Progress to date |
|---|---|
| **A Trauma Informed workforce** | Southampton Trauma Informed Practice (TIP) strategy developed<br>TIP working group set up to communicate and inform delivery of TIP across the city<br>Working with all partners in Southampton to sign up to the development of a Trauma informed workforce.<br>TIP training framework for all organisations in development<br>A mapped landscape of provision underway within the city to support those who have experienced trauma and diversity. |
| **Whole City Campaigns** | Partners working together to commit resources to a series of joint whole city comms campaigns targeted at healthy weight, smoking, mental health & harm from drug and alcohol. Progress to date includes:<br>• Joint campaign being prepared and led by Southern Health NHS Foundation Trust on suicide prevention<br>• Joint work to support smoke free programme, partnering with University Hospital Southampton NHS Foundation Trust.<br>• Process in place for agreeing joint work within fortnightly Southampton comms group meetings<br>• ICB drafting Southampton place achievements and successes, for consideration to use internally or externally as appropriate |
| **Pro-active Integrated Neighbour -hood Teams** | Southampton Primary and Local Care Transformation Delivery Group (PLCTD) set up with members from all agencies, NHS, social care and third sector.<br>The group has set out its objectives and work is underway to design and deliver<br>• Southampton Neighbourhood Operating Model<br>• Pro-active Case Management - Integrated Neighbourhood Team<br>• Acute Infection Hub/Same Day Access across primary care<br>• Urgent Care Response in the community<br>• Virtual Wards, Telemedicine |

# Health and Care Commitments

| Workstream | Progress to date |
| --- | --- |
| **Health and Wellbeing Infrastructure** | **Health in all policies (HiaP)**<br>HiAP Progress includes:<br>• Development of a new Tobacco, Alcohol and Drugs Strategy with significant involvement from teams across the council.<br>• Scoping of a whole systems approach towards the food environment in Southampton.<br>• Adoption of the Prevention Concordat for Better Mental Health, and development of a multi-agency partnership group of teams and organisations which influence the wider determinants of mental health and wellbeing in Southampton.<br><br>Development of a commitment for all partners to sign up to embedding health promoting activities within their organisations which include HiaP, Healthy Weight declaration, recruitment practice that targets opportunities towards vulnerable groups, smokefree settings, purchasing locally for social benefit and utilising public estate.<br><br>**Recruitment practice – vulnerable groups**<br>On track to support 400 people in target cohorts into paid employment each and to support up to 500 into training.<br>Securing funding remains a challenge to continue with the work.<br>Skills Team and Adult Learning Team budgets stabilised<br>SCC and DWP Partnership agreement finalised, focussing on:<br>• Unemployed Young People aged 18-24<br>• Unemployed people with health conditions and disabilities<br>• Unemployed people with a Secondary mental health condition and people recovering from substance/alcohol misuse<br>• Unemployed and workless people aged over 50<br>• Commissioned support to young people at risk of NEET (Aged 15/16) = project being drafted<br><br>**One public estate**<br>Working with all partners and agencies to make best use of public estate, including the co-location of workforce, support for communities and reduction of environmental impact. |

# Common Challenges across all Workstreams

| Challenges | Key actions |
|---|---|
| Increasing demand and complexity of need | • Strengthening early help and prevention<br>• Maintain clear understanding of current and future need forecasts<br>• Work with the market to adapt provision to meet those needs |
| Workforce shortages (across health and care sector) | • Joint recruitment campaigns – whole city approach to making Southampton a good place to work<br>• Collaborative working with providers in staff retention<br>• Continued exploration/evaluation/use of digital/different ways of working<br>• International recruitment<br>• Peer Support Worker expansion programmes<br>• Development of new roles promoting career progression e.g. clinical support workers, advanced practitioner programme |
| Financial pressures across the system | • Continued focus on Value for Money, identification of opportunities for streamlining provision, achieving efficiencies, reducing duplication<br>• Greater use of care technology and digital resources<br>• Balance of preventative work versus crisis care |
| Community and Voluntary Sector - Impact of cost of living pressures | • Working with the VCSE to develop infrastructure and support to attract external sources of funding, fund raising, sharing of resources – Young Southampton, Health and Care Alliance |
| Estate | • Commissioners and providers to work together to maximise utilisation across services and communities<br>• Review opportunities for SCC as Social Landlord to develop housing for vulnerable groups e.g. rough sleepers, people with LD |
| Strategic and financial context rapidly changing | • Ensure that our strategic vision is relatable and realistic<br>• Ensure that we engage actively with partners, other systems and patients/service users and their families |
| Economic impact on individuals – increasing deprivation | • Targeting provision to those most vulnerable populations/areas of deprivation<br>• Strengthening the early help and prevention offer |
| Care provider sustainability | • Monitor impact of cost of living on care provider sustainability (both operational and financial) with consideration of this within 2024/25 uplifts.<br>• Work with Skills for Care and Hampshire Care Association to identify support available to care market |

| | |
|---|---|
| **DECISION-MAKER:** | Health & Care Partnership Board |
| **SUBJECT:** | Better Care Fund 2023-2025 Update |
| **DATE OF DECISION:** | 19 October 2023 |
| **REPORT OF:** | **COUNCILLOR LORNA FIELKER**<br>**CABINET MEMBER FOR ADULTS, HEALTH AND HOUSING** |



| **CONTACT DETAILS** | | | | |
|---|---|---|---|---|
| **Executive Director** | **Title** | Wellbeing & Housing | | |
| | **Name:** | Claire Edgar | Tel: | 023 8083 3045 |
| | **E-mail:** | Claire.edgar@southampton.gov.uk | | |
| **Author**: | **Title** | Southampton Health & Care System Programme Manager<br>Deputy Director, Integrated Commissioning Unit | | |
| | **Name:** | Sarah Turner<br>Donna Chapman | Tel: | |
| | **E-mail:** | Sarah.turner69@nhs.net and d.chapman1@nhs.net | | |



| **STATEMENT OF CONFIDENTIALITY** |
|---|
| Not applicable. |
| **BRIEF SUMMARY** |
| The report provides an update on the Better Care Fund plan for 2023/25, in particular:<br>• Approval of plan by NHS England and expected future requirements<br>• Southampton's Better Care Fund performance for 2023/24 Quarter 1&2 |
| **RECOMMENDATIONS:** |

| | | |
|---|---|---|
| | (i) | For Southampton Health and Care Partnership to note the content of this report. |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| 1. | The Southampton Health & Care Partnership Board (SHCPB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to SHCPB from the Health and Wellbeing Board (HWBB). | |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | | |
| 2. | N/a | |
| **DETAIL (Including consultation carried out)** | | |
| 3. | **Background**<br><br>The Better Care Fund (BCF) Plan for Southampton has its basis in our 5 year Health and Care Strategy (2020 – 2025). This strategy was formed through a partnership of health, care and community and voluntary sector | |

| | |
|---|---|
| | representation and based on the Southampton Joint Strategic Needs Assessment (JSNA).<br><br>The plans address the priorities of supporting people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person, supporting the delivery of Next Steps to People at the Heart of Care. The vision is underpinned by 2 core objectives and delivered through the four core programmes.<br><br>Objectives:<br>• Enable people to stay well, safe, and independent at home for longer<br>• Provide people with the right care, at the right place, at the right time<br><br>Delivery programmes<br>• Start well<br>• Live well<br>• Age well<br>• Die well<br><br>**BCF local reporting and oversight**<br><br>The BCF Finance and Performance Group provide the oversight of the Better Care Fund S75 agreements and assurance to the Boards that the funding and performance are being appropriately and effectively managed and Southampton is compliant with the national conditions. The latest highlight report from the September meeting for previous two months is Appendix 1 for information. |
| 4. | **Policy Framework**<br><br>The Department of Health and Social Care published the BCF Policy Framework and Planning Guidance for 2023-25 on 5 April 2023. In summary, the BCF remains the government's vehicle for driving health and social care integration.<br><br>• Integrated Care Boards and local government are required to agree a joint plan which is owned and held to account by the Health and Wellbeing Board – agreed and signed off June 23.<br>• These plans use pooled budget arrangements to support integration, governed under Section 75 of the NHS Act (2006) to be signed off by 31 Oct 23.<br><br>The schemes within the Section 75 agreement support the delivery of Southampton's 5 year Health and Care Strategy whilst embracing the ethos of the BCF through the identified priorities.<br><br>**Priorities for 23/24 BCF Plan**<br><br>Priority 1 **Delivering on Avoidable Admissions to enable people to stay well, safe, and independent at home for longer** |

| | |
|---|---|
| | Strong focus on prevention, admission avoidance through our Urgent Response Service, proactive care at home (reducing preventable admission to long term care), carers services and Enhanced Health in Care Homes (EHCH) arrangements.<br><br>Priority 2 **Further developing the discharge model to promote right care in the right place at the right time**<br>• Recovery and Assessment and Home First<br>• Hospital Discharge process and out of hospital capacity<br>• Recovery and assessment, promoting a home first approach<br>• Focus on discharge capacity for those with the most complex needs<br><br>Priority 3 **Supporting unpaid carers**<br><br>Priority 4 **Effective utilisation of the Disability Facilities Grant** promoting independence and personalised care/strength-based approaches<br><br>Priority 5 **Health and Health Inequalities** reducing health inequalities and disparities for local population, taking account of people with protected characteristics<br><br>Southampton's Better Care Narrative and Planning submission for 2023-25 has been formally approved by NHS England (Appendix 2). Southampton is now in the process of finalising the Section 75 agreement for sign off before 31 October 2023. The Health and Care Partnership Board are asked to note the NHS England letter. |
| 5. | **BCF future national requirements**<br><br>Quarterly reporting will be recommencing from Q2 this year, due 31 October 2023. Q2 will require a review of the intermediate capacity and demand plan submitted in June 23 to ensure alignment with the Integrated Care Board's Winter plan and urgent and emergency care recovery plans.<br><br>From Q3, areas will be required to set ambitions for a new metric that measures timely discharge. This metric will measure the time from the discharge ready date to the actual date of discharge. Within the development of this metric, consideration will include the clinically ready for discharge metric for mental health, leaning disability and autism services. |
| 6. | **2023/24 Quarter 1&2 performance**<br><br>**Financial Performance – to end of Month 5 (Month 6 currently unavailable)** |

| BCF Funding 2023/4 | Planned £'000 | Forecast £'000 | Variance £'000 |
|---|---|---|---|
| ICB | £98,088 | £98,853 | £766 |
| SCC | £58,096 | £58,980 | £883 |
| BCF Discharge Fund (ASCDF) | £3,130 | £3,130 | £0 |
| Disabled Facility Grant (DFG) inc c/f from previous years | £8,084 | £4,837 | £(3,246) |
| **Total** | **£167,398** | **£165,800** | **£(1,598)** |

**Variation from plan**

There are two main areas which are primarily impacting on the planned budget:

- **Changes in Learning Disability packages** causes fluctuations in overall budget. Due to the complexity of these individuals, a change in one person's care has a significant impact, positively or negatively, on the budget. In addition service provision which had increased due to uplifts have recently been agreed with providers and backdated to 1 April 2023.
    - ICB: Current forecast overspend of £526k
    - SCC: Current forecast for this service is £643k overspend

- **Joint Equipment (JES).** Across each of the prescribing organisations, numbers of orders have increased in August compared to last year along with repair costs increasing. Further work is underway to better understand where these increases are, whether they will persist for the remainder of 2023/24 and what mitigations can be put in place.
    - ICB: Current forecast overspend of £193k
    - SCC: Current forecast overspend of £195k

**Disability Facility Grant (DFG)**

- The DFG is forecasting an underspend of £3,247k and steps have been put into place to expedite client backlog.

**Market and Sustainability Fund**

The Market Sustainability Grant of £1,687k was added at month 4.

7.

## Q2 Metrics position

| BCF National Metrics | Q1 | | Q2 | |
|---|---|---|---|---|
| | Planned | Actual | Planned | Actual |
| **Avoidable Admissions** Unplanned hospitalisation for chronic ambulatory care sensitive condition rate of admissions per 100,000 population | 218.41 | 244.00 | 200.45 | 186.85* |
| **Falls** Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 | 596.45 | 589.82 | 596.45 | 570.24* |
| **Discharge to normal place of residence** Percentage of people who are discharged from acute hospital to their normal place of residence | 95.00% | 95.34% | 95.00% | 93.71%* |
| **Residential Admission** Rate of permanent admissions to residential care per 100,000 population (65+) | 140.47 | 189.00 | 140.47 | TBC |
| **Reablement** Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | 75.00% | | | ** |

***Q2 data to be validated as not complete**
**Data currently manually collected between Oct- Dec, reporting provided Jan-Mar 24 in line with national reporting timeframes). Systems underway to see if this data can be reported digitally locally to enable more frequent reporting.

### Metric narrative

Admission Avoidance

Performance has improved from quarter 1 to quarter 2. Key areas underpinning the performance of this metric are:

- The development of Proactive Case Management, Urgent Community Response (URS) and Virtual Wards will have an impact on responsivity.
- URS are working with South Central Ambulance Service (SCAS) to restart the arrangement where URS received referrals directly from the SCAS Urgent Care Desk. This was viewed as being successful in terms of hospital avoidance as URS can attend quickly as an Urgent Community Response function assessing the patient within 2 hours and putting in place support wherever possible keeping the patient in their home.

Falls

An increase in over 65s is leading to an increase in demand. Plans to improve performance are aligned with the Admission Avoidance work but specific work in relation to falls includes:

- Continued Focus on Falls through the Falls Link Meeting that brings together a range of professionals from across the City.
- Audit programme in place looking at a range of falls related issues e.g. medication, follow ups etc.
- URS and Community Independence Service (CIS) also undertake the Comprehensive Falls Assessments (RAG rated) which can then be undertaken rapidly through internal referral when URS picks up a falls referral from SCAS (as mentioned above)

- The Saints Foundation who provide Falls Recovery Classes increasing the workforce expertise in relation to Falls.
- CIS have started to roll out vestibular work (balance exercises) as there is evidence that there is an increase in the incidences of vertigo in older patients

<u>Discharge to normal place of residence</u>
We have based our ambition on consistently achieving 95% throughout 23/24 based on the national expectations. We continue to strengthen our focus on home first through:

- Increasing community health and social care presence on the hospital site to be part of early discharge discussions with staff and families, promoting the home first messages and culture;
- Strengthening our reablement offer to support more people on Pathway1;
- Increased partnership working with the VCSE through our BCSE hospital discharge navigation pilot which will go live in November to connect people with the support available in their own communities to keep them well and prevent social isolation.

<u>Residential Admissions</u>
Southampton has seen a steady improvement in performance over the last 4 years however, particularly given the increased complexity across the system and the capacity within our teams to ensure timely assessment and reviews, sustaining this area of work is challenging. We will be looking to further improve on this metric through:

- Continued focus on strengths based practice across the system, promoting the home first message
- Expanding our reablement offer to focus on community referrals as well as hospital discharge
- Strengthening reablement through increasing therapy oversight to assessment and review process to ensure goals are realistic and met
- A stronger focus on Home First for hospital discharge
- Greater use of technology and equipment to support people in their own homes, ensuring that this is central to the assessment process

<u>Reablement</u>
Data for this metric has historically been reported annually in line with the Adult Social Care Outcomes Framework (ASCOF) reporting requirements; however work is underway to find a way of reporting the metric more frequently locally, in addition to establishing a monthly reablement dashboard of local metrics to measure performance. This will include data on the effectiveness of reablement – during August 2023 which was the first month of reporting on the local dashboard showed that of the 109 people who completed reablement in August 2023, 70% were independent at the end of their support (national expectation is 60%).
We are aiming to expand capacity (for community referrals) and increase therapy oversight. A reablement service transformation is in place to support this work.

8. **Disability Facility Grant (DFG)**

There have been some significant challenges facilitating the DFG which has led to a backlog of clients. A plan has been put into place to clear this backlog.

Following on from a key recommendation that was made in the Foundations independent review of the Council's DFG delivery, in June this year the Council published a revised Housing Assistance Policy, which builds on and refreshes the previous policy that was published in 2019. The new policy will enable the DFG team to deliver home adaptations for the city's residents in a more flexible way.

We are recruiting for two new DFG case workers. These posts will focus on proactive DFG client engagement as well as the administrative work that is vital to swiftly processing DFGs. The additional resource provided by the caseworker posts will free up more time for the team's Housing Technical Officers to focus on client home visits and day-to-day DFG delivery. We are also recruiting two Housing Technical Officers to help bolster existing resource. Subject to a successful recruitment process we expect to have these posts in place as soon as possible.

Fast-tracking DFG Delivery and increasing contractor availability. This should enable the team to clear the client backlog by approximately 55 cases in the next quarter from an overall cohort of 350 clients who require home adaptations. The remainder of the client backlog require level access shower works. An existing barrier to DFG delivery has been a lack of available contractors to carry out the works. The service is working with SCC Procurement and Trading Standards to increase the number of contractors available to the DFG Team on the council's "Buy-With-Confidence" (BWC) list. To address the longer-term contractor availability issue, the service is working with Procurement on a business case to support an open tender exercise for a framework agreement /call-off contract that local contractors would bid for.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

9. The overall pooled fund for 2023/2024 as at month 5 is £167,398,000, split as follows:

| **BCF Funding 2023/4** | **Planned £'000** |
|---|---|
| ICB | £98,088 |
| SCC (including the iBCF allocation) | £58,096 |
| BCF Discharge Fund (ASCDF) | £3,130 |
| Disabled Facility Grant (DFG) inc c/f from previous years | £8,084 |
| **Total** | **£167,398** |

| | |
|---|---|
| **Property/Other** | |
| 10. | Not applicable |
| **LEGAL IMPLICATIONS** | |
| **Statutory power to undertake proposals in the report:** | |
| 11. | Not applicable – briefing only |
| **Other Legal Implications:** | |
| 12. | Not applicable |
| **RISK MANAGEMENT IMPLICATIONS** | |
| 13. | The risks are as follows –<br>There is a risk of overspend against a small number of schemes within the pooled fund. Each scheme is under close scrutiny and where possible the overspend is mitigated, but will be notified when mitigation is at risk<br><br>Specific risks are provided in the current highlight report attached at Appendix 1. |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 14. | The BCF planning and narrative plan for 2023-24 were submitted on 28 June 2023 and they have been approved by NHS England.<br><br>The Better Care Finance and Performance Group will be providing the assurance to Southampton Health and Care Partnership Board on the delivery of the Better Care Fund against the plan. Areas of concern will be escalated as appropriate and in line with the governance and assurance process.<br><br>New reporting and oversight is being required by NHS England starting from Q2 as outlined in this briefing. Reporting processes and mechanisms are required locally to ensure monitoring of performance and metrics, as required by the national team, may be provided, also informing the year end return. |

| | |
|---|---|
| **KEY DECISION?** | **No** |
| **WARDS/COMMUNITIES AFFECTED:** | **All** |

SUPPORTING DOCUMENTATION

| | |
|---|---|
| **Appendices** | |
| 1. | Southampton BCF Finance and Performance Highlight Report Sept 23 |
| 2. | NHS England BCF approval letter. |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | |
| 2. | |
| **Equality Impact Assessment** | |

| | | |
|---|---|---|
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | | **No** |
| **Data Protection Impact Assessment** | | |
| **Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.** | | **No** |
| **Other Background Documents**<br>**Other Background documents available for inspection at:** | | |
| **Title of Background Paper(s)** | | **Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)** |
| 1. | | |
| 2. | | |

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# Highlight & Exception Report

| Programme Name | Southampton BCF Finance and Performance Group |
|---|---|

## High Level Description of Programme

Summary Highlight Report for the BCF finance and performance group Month 5

## Highlights

**Looking back:** Key activities completed in the last 8 weeks

1 - NHSE letter received. BCF plan approved

2 - Guidance received on new reporting to be completed and sign off required

3 - Finance Areas to note at Month 3
Start Well
- None to date

4 - Live Well
As per previous reporting
- Rows 38/41: LD Placements/Packages. Forecast overspend due to complexities of fluctuatin

5 - Age Well
- Row 102/106: JES contract. Increase in orders across all organisations. Significant oversper meeting to share insight.
- Rows 107/108: DFG, unspent funds will be rolled forward into next year as per previous mee

6 - Summary
Currently forecasting £1.59m overspend

## Key Risks, Issues & Escalations

Note - open risks with a current score of 12 or more and issues with a current score of 15 c

| Description | |
|---|---|

| Risk/Issue | Title | What could happen/ has happened? | Because of what? | Probability |
|---|---|---|---|---|
| Risk | **DFG** | Waiting list is not reduced as expected as per NHSE expectation and monitoring of finances | Staffing, adaption equipment, general processes. | 3 - Possible |
| Issue | **LD Placements/ Packages** | Budget significantly overspent | Cost of individuals can impact on the budget greatly and is challenging to plan for | 4 - Likely |
| Issue | **JES contract** | Budget overspend | All organisations seeing an in increase in orders | 4 - Likely |
| | | | | |
| | | | | |
| | | | | |

| | **Looking forward:** Key activities due to be c |
|---|---|
| | 1 - S75 agreement to be updated and signed off by 3 |
| | 2 - Quarterly reporting to start. First return due 31 Oc |
| | 3 - |
| g LD package numbers | 4 - |
| ıd. Monitoring required. SM invited to ting. | 5 - |
| | 6 |

r more will be automatically populated from the risks and issues log into the table below

| **Current Score** | **Management** |
|---|---|

| Impact | Score | | Controls already in place<br>Things that are already in place that have minimised or managed the impact of the risk should it materialise or the impact of the issue if it has materialised, or the likelihood of the risk materialising. | Further actions required<br>Actions required to further mitigate the risk or manage the issue to an acceptable level. |
|---|---|---|---|---|
| 3 - Moderate | 9 | High | Procedures and processes are in place to expedite waiting list | Monitor |
| 4 - Major | 16 | Very High | Monitoring of the budget and escalate | Monitor |
| 4 - Major | 16 | Very High | Monitoring of the budget. An understanding of the increase in orders. | Monitor |
| | | | | |
| | | | | |
| | | | | |

| Programme Team | |
|---|---|
| Senior Responsible Executive (SRE) | Cllr Fielker |
| Senior Responsible Owner (SRO) | Terry Clark |
| Operational Lead | Donna Chapman |
| Programme Manager | Sarah Turner |

## ompleted in the next 8 weeks

1 October 23

ctober 23 and signed off by HWB. Included in the return is a refresh of Capacity and Demand plan.

**Escalation**

| Requires Escalation? | Why does it need escalation? | Where is it being escalated to? | Action Requested |
|---|---|---|---|
| No | | | |
| No | | | |
| No | | | |
| | | | |
| | | | |
| | | | |

## Info & Guidance

Complete the white boxes (note, some cells will autopopulate using information from other tabs in the workbook)

Please keep your highlights high level and succinct - the report is to demonstrate key actions or deliverables that have been achieved over the past 4 weeks, or what's on track to be achieved over the next 4 weeks.

**Risk/Issue scoring matrix**

What's the difference between a risk and an issue?
- A risk is something that could happen.
- An issue is something that has happened. All issues therefore have a probability rating of 5 (certain).

| Risk and Issue Score | | Probability | | | | |
|---|---|---|---|---|---|---|
| | | 1 Very Unlikely | 2 Unlikely | 3 Possible | 4 Likely | 5 Almost Certain |
| Impact to the Project | 5 Catas-trophic | 5 Medium | 10 High | 15 Very High | 20 Very High | 25 Very High |
| | 4 Major | 4 Medium | 8 High | 12 High | 16 Very High | 20 Very High |
| | 3 Moderate | 3 Low | 6 Medium | 9 High | 12 High | 15 Very High |
| | 2 Minor | 2 Low | 4 Medium | 6 Medium | 8 High | 10 High |
| | 1 Negligible | 1 Low | 2 Low | 3 Low | 4 Medium | 5 Medium |

NHS England

NHS England
Wellington House
133-155 Waterloo Road
London,
SE1 8UG
E-mail:
england.bettercarefundteam@nhs.net

To: *(by email)*
Cllr Lorna Fielker, Chair, Southampton Health and Wellbeing Board
James House, Integrated Care Board Chief Executive or Representative(s)
Mike Harris, Chief Executive,
Southampton City Council

18 September 2023

Dear Colleagues,

**BETTER CARE FUND 2023-25**

Thank you for submitting your Better Care Fund ("**BCF**") plan for regional assurance and approval. I am pleased to let you know that following this process, your plan has been classified as '**approved**'. You should now proceed to finalise your section 75 agreements with a view to these being signed off by 31 October 2023.

We are grateful for your commitment to developing and producing your agreed plan and we recognise that there are many pressures on local system colleagues, despite the early publication of the planning requirements.

The BCF is the only mandatory policy to facilitate the integration of health, social care and housing funding. This is the second time that the BCF Policy Framework covers two financial years to align with NHS planning timetables and to give areas

the opportunity to plan more strategically.

**BCF Conditions for financial year 2023/4**

The BCF funding from NHS England for the financial year 2023/24, which includes additional discharge funding, can now be formally released subject to compliance with the following conditions (referred to as "the **BCF Conditions**"):

- The BCF funding is used in accordance with your final approved plan.
- The national conditions ("the **National Conditions**") set out in the BCF Policy Framework for 2023-25 and further detailed in the BCF Planning Requirements for 2023-25 continue to be met.
- Satisfactory progress is made towards meeting the performance objectives specified in your BCF plan.
- Reports on your area's progress and performance are provided to NHS England in accordance with relevant guidance and any requests made by NHS England and governmental departments. This includes quarterly reporting on the BCF overall and fortnightly reporting on use of the Additional Discharge Funding, as set out in the Planning Requirements document.

**Escalation**

The BCF Conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006. This means that if the BCF Conditions are not complied with NHS England can, under section 223GA:

- withhold any payment, if any of the BCF Funding has not already been made available to the ICB;
- recover any of the funding (either from the current financial year or a subsequent financial year); and/or
- direct the ICB or ICBs in your Health and Wellbeing Board area as to the use of the funding.

Where an area is not compliant with one or more BCF Conditions or there is a material risk that a BCF Condition will not be met, an area may enter into escalation, as outlined in the BCF Planning Requirements 2023-25. This could lead to NHS England exercising the powers outlined above. Any intervention will be proportionate to the risk or issue identified.

**Local authority funding for financial year 2023/4**

Grants to local government (improved Better Care Fund, Additional Discharge Fund

and Disabled Facilities Grant) will continue to be paid to local government under s31 of the Local Government Act 2003, via the Department of Levelling Up, Housing and Communities, with a condition that they are pooled into one or more pooled funds under section 75 of the NHS Act 2006 and spent in accordance with your approved BCF plan.

**Reporting and compliance**

Ongoing support and oversight regarding the spending of BCF funding will continue to be led by your local Better Care Manager ("**BCM**"). Following regional assurance, we are asking all BCMs to feed back to local systems where the process identified areas for improvement in plans, including where systems may benefit from conversations with other areas. Nationally, we will also be reflecting on the data and what further support we can consider in the future.

Reporting on the overall BCF programme for 2023-25 will resume in September with quarterly reporting and an end of year return. In preparation for winter and to ensure ongoing alignment with urgent and emergency care recovery plans, the Quarter 2 report will include a check that your Intermediate Care Capacity and Demand plans are still fit for purpose as we enter months where capacity is often stretched. Your refreshed Intermediate Care Capacity and Demand plan needs to be submitted by 31 October 2023. All templates and guidance will be published on the Better Care Exchange. Further information on quarterly and end of year reporting will be confirmed in due course.

You will be aware that there are additional reporting requirements for the Additional Discharge Fund. The Government maintains a strong interest in improving timely discharge of patients; details of additional reporting on this part of the fund have been published. NHS England also requires a monthly return on packages provided to date, spend to date and forecast spend data on an ICB footprint. There is a commitment to review these reporting arrangements for 2024-25.

**BCF Conditions for financial year 2023/24**

As explained above, the BCF Policy Framework covers the financial years 2023/24 and 2024/25. NHS England expects that before any BCF funding for 2024/25 is made available it will write to areas to notify them that the BCF Conditions for 2023/24 set out in this letter will also apply to 2024/25.

If your area is in breach of its BCF Conditions or there is a material risk that it will breach a BCF Condition, then further conditions may be applied to BCF funding for

2024/25.

Once again, thank you for your work and best wishes with implementation and ongoing delivery.

Yours sincerely,

**Nicola Hunt**

Senior Responsible Officer for the Better Care Fund
NHS England

Copy (by email) to:

Anne Eden, Regional Director, NHS England
Rosie Seymour, Programme Director, Better Care Fund team, Better Care Fund Programme, NHS England
Natalie Jones, Better Care Manager, Better Care Fund Programme, NHS England